

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>002999</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEARTH AT WINDERMERE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9745 OLYMPIA DR</b> <b>FISHERS, IN 46038</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Post Survey Revisit (PSR) to the State Residential Licensure Survey, completed on June 30, 2016.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00205098 and Complaint IN00205530.</p> <p>Survey dates: July 31, August 1 and 2, 2016</p> <p>Facility number: 002999 Provider number: N/A AIM number: N/A</p> <p>Census bed type: SNF/NF: 117 Total: 117</p> <p>Census payor type: Other: 117 Total: 117</p> <p>Sample: 3</p> <p>Hearth at Windermere was found to be in compliance with 410 IAC 16.2-5.1 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality review completed by 30576 on August 9, 2016</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE